

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>345316</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>03/12/2026</b>
NAME OF PROVIDER OR SUPPLIER <b>Senior Citizens Home</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2275 Ruin Creek Road , Henderson, North Carolina, 27537</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments  An unannounced recertification and complaint investigation survey was conducted on 3/9/2026 through 3/12/2026. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1F26C4-H1.	E0000		
F0000	INITIAL COMMENTS  A recertification and complaint investigation survey was conducted from 3/9/2026 through 3/12/2026. Event ID# 1F26C4-H1. The following intakes were investigated 2601363 and 839572.  4 of the 4 complaint allegations did not result in deficiency.	F0000		
F0641 SS = A	Accuracy of Assessments  CFR(s): 483.20(g)(h)(i)(j)  §483.20(g) Accuracy of Assessments.  The assessment must accurately reflect the resident's status.  §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  §483.20(i) Certification.  §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.  §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  §483.20(j) Penalty for Falsification.  §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F0641		04/04/2026

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0641 SS = A	Continued from page 1  (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or  (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.  §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is NOT MET as evidenced by:  Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Discharge Return Not Anticipated. This occurred for 1 of 20 residents whose MDS assessments were reviewed (Resident #12).  The findings included:  Resident #12 was admitted on 2/08/26.  Review of the nurse note dated 2/06/26 revealed Resident # 12 was observed in a state of confusion, VS (vital signs) were obtained, the NP (Nurse Practitioner) was notified, and staff were advised to send the resident to the Emergency Room for evaluation.  Review of Resident #12's discharge Minimum Data Set (MDS) assessment dated 2/06/26 indicated that Resident #12 was coded as a Discharge Return Not Anticipated.  Resident #12's Minimum Data Set dated 2/08/26 coded the Resident as an entry.  In an interview on 3/11/26 at 10:42 AM the Minimum Data Set Nurse indicated two residents had the same last name at the time of transfer and she must have mixed the residents up.  In an interview on 3/12/26 at 10:51 AM the Administrator stated she expected the MDS staff to make accurate resident assessments.	F0641		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records  CFR(s): 483.45(a)(b)(1)-(3)  §483.45 Pharmacy Services  The facility must provide routine and emergency drugs	F0755	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice  On 2/8/26, medications to include the anti-convulsant, anti-psychotic, and triple-therapy bronchodilator were made available to Resident #59 by the license nurse.	04/04/2026

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F0755 SS = D	<p>Continued from page 2 and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, and interviews with staff, Director of Nursing, Nurse Practitioner, Pharmacy Technician, and Pharmacist, the facility failed to provide services to ensure the acquiring, dispensing, and administration of medications for 1 of 5 sampled residents whose medications were reviewed (Resident #59). The facility failed to have an anticonvulsant, antipsychotic, and a triple-therapy bronchodilator available for administration to Resident #59.</p> <p>The findings included:</p> <p>Resident #59 was admitted to the facility on 2/5/26 with diagnoses that included COPD, depression and bipolar disorder.</p> <p>a. Resident #59 had a physician order initiated on</p>	F0755	<p>Continued from page 2</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice</p> <p>Residents residing in the facility have the potential to be affected by the deficient practice. On 4/1/26 the Director of Nursing reviewed current resident's physician orders compared to the medication card/medication storage using the Medication availability audit to ensure medications were available. Any concerns identified during thew audit will be immediately addressed by the Director of Nursing to include obtaining medications and/or notification of the provider. The audit will be completed by 4/3/26</p> <p>Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur</p> <p>On 4/2/26 education was provided by the Director of Nursing and Assistant Director of Nursing to the nurses regarding ordering and administration of medications. The nurses were re-educated on the proper way to order medications. Pharmacy dispensing/delivery was reviewed and the timeliness of administration. In the event the medication cannot be received and administered in the time frame the physician will be contacted for an alternate instruction or hold order. Nurses that have not received the education by 4/4/26 will not be able to work next shift until education has been received. Newly hired nurses will receive the education in orientation from the Director of Nursing.</p> <p>Indicate how the facility plans to monitor its performance to make sure solutions are sustained</p> <p>The Director of Nursing or designee will audit ten residents a week for four weeks, then seven residents a week for four weeks, then five residents a week for four weeks to ensure that medications are acquired, dispensed and administered timely and as ordered using the medication cart to chart review.</p> <p>The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.</p> <p>Indicate date when corrective action will be completed</p>	

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F0755 SS = D	<p>Continued from page 3 2/5/26 for Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 milligrams(mg) (an anticonvulsant medication sometimes used for mood stabilization)- Give 1000 mg by mouth at bedtime for bipolar disorder.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Divalproex Sodium was not administered on 2/6/26 by Nurse #1, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/6/25 at 8:34 PM and written by Nurse #1 revealed Divalproex Sodium medication was on order.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Divalproex Sodium was not administered on 2/8/26 by Nurse #1, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/8/25 at 8:32 PM and written by Nurse #1 revealed Divalproex Sodium medication was on order.</p> <p>b. Resident #59 had a physician order initiated on 2/5/26 for Olanzapine 2.5 mg tablet (an antipsychotic medication)- Give 2.5 mg by mouth at bedtime for bipolar disorder.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Olanzapine was not administered on 2/6/26 by Nurse #1, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/6/25 at 8:35 PM and written by Nurse #1 revealed Olanzapine medication was on order.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Olanzapine was not administered on 2/7/26 by Nurse #2, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/7/26 at 9:37 PM and written by Nurse #2 revealed Olanzapine medication was on order.</p>	F0755	Continued from page 3 Completion date: 4/4/26	

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F0755 SS = D	<p>Continued from page 4</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Olanzapine was not administered on 2/8/26 by Nurse #1, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/8/25 at 8:32 PM and written by Nurse #1 revealed Olanzapine medication was on order.</p> <p>c. Resident #59 had a physician order initiated on 2/5/26 for Trelegy Ellipta Inhalation Aerosol powder Breath Activated 200-62.5-25 milligrams per actuation (mg/act) Fluticasone Umeclidinium-Vilanterol- One puff -inhale orally one time a day for Chronic Obstructive Pulmonary Disease (COPD).</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/6/26 by Nurse #1, with a chart code that referenced the progress notes.</p> <p>Review of a Medication Administration note dated 2/6/26 at 1:29 PM and written by Nurse #1 revealed Trelegy Ellipta medication was on order.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/7/26 by Nurse #2, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/7/26 at 3:06 PM and written by Nurse #2 revealed Trelegy Ellipta was on order.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/8/26 by Nurse #1, with a chart code that referenced the progress notes.</p> <p>A health status note dated 2/8/26 at 6:19 PM and written by Nurse #1 revealed the on-call provider was notified that the facility was still awaiting delivery of Resident #58's medication from pharmacy. Nurse #1 documented staff to continue to monitor.</p>	F0755		

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F0755 SS = D	<p>Continued from page 5</p> <p>A Medication Administration note dated 2/8/26 at 9:45 PM and written by Nurse #1 revealed Trelegly Ellipta medication was on order.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegly Ellipta was not administered on 2/9/26 by Nurse #3, with a chart code that referenced the progress notes.</p> <p>Review of the electronic medical record revealed no documentation of a medication administration note written by Nurse #3 on 2/9/26.</p> <p>Nurse #1 was interviewed on 3/10/26 at 2:29 PM. Nurse #1 stated that when a resident was newly admitted to the facility it could take a little while for the residents to receive their medications from the pharmacy. Nurse #1 stated she did not check the pyxis (an automated, secure, and centralized system used in healthcare to manage the storage, dispensing, and tracking of medications) on 2/6/25 to see if medications were available for Resident #59. Nurse #1 stated that when medications were not available the provider was notified and a follow-up phone call was placed to the pharmacy. Nurse #1 stated she placed a call to the on-call provider on 2/8/26 to notify the provider that the facility was still awaiting delivery of Resident #59's medications. Nurse #1 stated in some cases the nurse has reached out to the resident representative to see if the resident had a supply of the medication at home. Nurse #1 denied reaching out to Resident #59's family.</p> <p>Nurse #2 was interviewed on 3/10/26 at 4:26 PM. Nurse #2 stated when Resident #59 was admitted he did not get all his medications delivered from the pharmacy. Nurse #2 stated Resident #59's medications were ordered from the pharmacy when he was admitted by the administrative nurses. Nurse #2 stated the administrative nurses were responsible for entering the physician orders and verifying the orders with the discharge summary and ordering medications from the pharmacy. Nurse #2 stated when medications were not received from the pharmacy the nurse followed up with pharmacy about medication status. Nurse #2 further stated the provider was notified that Resident #59 did not have his Trelegly inhaler on 2/7/26 for further orders and the pharmacy was notified. Nurse #2 stated she was instructed to monitor resident.</p>	F0755		

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F0755 SS = D	<p>Continued from page 6</p> <p>Nurse #3 who administered Resident #59's medication on 2/9/26 did not respond to a request for interview.</p> <p>An interview was conducted with the Pharmacist Services Technician on 3/10/26 at 2:12 PM. The technician verified that Resident #59's Trelegy Ellipta, Depakote and Olanzapine medication orders were received from the facility on 2/9/26 and the medications were delivered the evening of 2/9/26.</p> <p>An interview was conducted with the Director of Nursing on 3/11/26 at 2:23 PM. The DON stated the previous process was for the physician order to be entered into the electronic medical record and the information was transmitted to the pharmacy electronically. The DON stated the facility had just switched over to a new pharmacy on 2/1/26. The DON stated the facility was not aware that Resident #59's medication orders had not been transmitted electronically to the pharmacy on 2/5/26. The DON stated she was notified by Nurse #3 on 2/9/26 that Resident #59 did not have his Trelegy inhaler. The DON stated once she became aware of the issue on 2/9/26 she faxed the physician orders for Trelegy, Olanzapine and Divalproex Sodium for Resident #59 to the pharmacy. The DON stated she could not recall any education from the pharmacy during the transition training about the transmittal process for orders changing. The DON stated that when a resident missed a medication the nurse was supposed to follow up with the pharmacy and the provider. The DON further stated the nurses had access to the medication pyxis which housed emergency medications and frequently used medications. The DON stated the facility had not been faxing orders to the pharmacy prior to 2/1/26.</p> <p>An interview was conducted with the Pharmacist on 3/12/26 at 11:44 AM. The pharmacist revealed orders were received from the facility for Resident #59 via fax on 2/9/26. The Pharmacist verified orders for Depakote 125mg, Olanzapine 2.5 mg and Trelegy Ellipta were received and the medications were delivered to the facility on the second pharmacy delivery at 7:00 PM on 2/9/26. The Pharmacist revealed the facility had received education from the pharmacy staff on the new pharmacy process prior to the system change on 2/1/26. The Pharmacist stated changes to the process for submitting physician orders which included physician orders that were to be faxed to the pharmacy were included in the in-service education. She further</p>	F0755		

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F0755 SS = D	Continued from page 7 stated that pharmacy staff were at the facility before the pharmacy switch over and during the transition.  During an interview with the Administrator on 3/12/26 at 11:32 AM, she stated the facility changed to a new pharmacy on 2/1/26. The Administrator stated that the staff was trying to get acclimated with the new pharmacy. The Administrator stated she was made aware that there was an issue with the integration of the new system. The Administrator stated the facility had no knowledge that there was an issue with the transmission of medication orders until the issue with Resident #59's medications was brought to the nursing staff's attention. The Administrator stated the nursing staff was under the impression that the orders would be transmitted electronically just like the previous system. The Administrator stated when the DON followed up on 2/9/26 with the pharmacy, it was discovered there was an interface problem with the current system communicating to the new pharmacy.	F0755		
F0760 SS = D	Residents are Free of Significant Med Errors  CFR(s): 483.45(f)(2)  The facility must ensure that its-  §483.45(f)(2) Residents are free of any significant medication errors.  This REQUIREMENT is NOT MET as evidenced by:  Based on record review, and interviews with staff, Nurse Practitioner, Pharmacist, Assistant Director of Nursing, and Director of Nursing, the facility failed to prevent a significant medication error for 1 of 5 residents whose medications were reviewed (Resident #59). The facility failed to administer prescribed antipsychotic medication, anticonvulsant medication and triple therapy bronchodilator to Resident #59.  The findings included:  Resident #59 was admitted to the facility on 2/5/26 with diagnoses that included chronic obstructive pulmonary disease (COPD), depression and bipolar disorder.  a. Resident #59 had a physician order initiated on 2/5/26 for Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 milligrams(mg) (an anticonvulsant medication sometimes used for mood stabilization) Give 1000 mg by mouth at bedtime for bipolar disorder.	F0760	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice  On 2/8/26, medications to include the anti-convulsant, anti-psychotic, and triple-therapy bronchodilator were made available to Resident #59 by the license nurse.  Address how the facility will identify other residents having the potential to be affected by the same deficient practice  Residents currently residing in the facility have the potential to be affected by the deficient practice. On 4/3/26 the Director of Nursing reviewed the current resident's electronic medication administration record for the last 14 days to ensure medications were administered as ordered. Any issues identified were relayed to the physician.  Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur  On 4/2/26 education was provided by the Director of Nursing and Assistant Director of Nursing to the nurses regarding ordering and administration of medications. The nurses were re-educated on the proper way to order medications. Pharmacy dispensing/delivery was reviewed and the timeliness of administration. In the event the medication cannot be received and administered in the time frame the physician will be contacted for an	04/04/2026

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F0760 SS = D	<p>Continued from page 8</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Divalproex Sodium was not administered on 2/6/26 by Nurse #1, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/6/25 at 8:34 PM and written by Nurse #1 revealed Divalproex Sodium medication was on order.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Divalproex Sodium was not administered on 2/8/26 by Nurse #1, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/8/25 at 8:32 PM and written by Nurse #1 revealed Divalproex Sodium medication was on order.</p> <p>b. Resident #59 had a physician order initiated on 2/5/26 for Olanzapine 2.5 mg tablet (an antipsychotic medication) Give 2.5 mg by mouth at bedtime for bipolar disorder.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Olanzapine was not administered on 2/6/26 by Nurse #1, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/6/25 at 8:35 PM and written by Nurse #1 revealed Olanzapine medication was on order.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Olanzapine was not administered on 2/7/26 by Nurse #2, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/7/26 at 9:37 PM and written by Nurse #2 revealed Olanzapine medication was on order.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Olanzapine was not administered on 2/8/26 by Nurse #1, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/8/25 at 8:32 PM and written by Nurse #1 revealed Olanzapine medication was on order.</p> <p>c. Resident #59 had a physician order initiated on 2/5/26 for Trelegy Ellipta Inhalation Aerosol powder Breath Activated 200-62.5-25 milligrams per actuation</p>	F0760	<p>Continued from page 8</p> <p>alternate instruction or hold order. Nurses were also informed to make the Director of Nursing aware of medications that were not in the cart. Furthermore, nurses were educated on the use of the pharmacy back up system through a local pharmacy for dispensing. Nurses that have not received the education by 4/4/26 will not be able to work next shift until education has been received. Newly hired nurses will receive the education in orientation from the Director of Nursing.</p> <p>Indicate how the facility plans to monitor its performance to make sure solutions are sustained</p> <p>The Director of Nursing or designee will audit ten residents a week for four weeks, then seven residents a week for four weeks, then five residents a week for four weeks to ensure that medications are administered as prescribed. Use EMAR review audit tool.</p> <p>The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.</p> <p>Indicate date when corrective action will be completed</p> <p>Completion date: 4/4/26</p>	

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>345316</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>03/12/2026</b>
NAME OF PROVIDER OR SUPPLIER <b>Senior Citizens Home</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2275 Ruin Creek Road , Henderson, North Carolina, 27537</b>	
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F0760 SS = D	<p>Continued from page 9 (mg/act) Fluticasone Umeclidinium-Vilanterol. One puff -inhale orally one time a day for COPD.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/6/26 by Nurse #1, with a chart code that referenced the progress notes.</p> <p>Review of a Medication Administration note dated 2/6/26 at 1:29 PM and written by Nurse #1 revealed Trelegy Ellipta medication was on order.</p> <p>A health status note dated 2/6/26 and written by Nurse #1 revealed Resident #59 was on oxygen at 2 liters per minute via nasal cannula. Resident #59's respirations were even and unlabored.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/7/26 by Nurse #2, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/7/26 at 3:06 PM and written by Nurse #2 revealed Trelegy Ellipta was on order.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/8/26 by Nurse #1, with a chart code that referenced the progress notes.</p> <p>A Medication Administration note dated 2/8/26 at 9:45 PM and written by Nurse #1 revealed Trelegy Ellipta medication was on order.</p> <p>Documentation on the February Medication Administration Record (MAR) for Resident #59 revealed that Trelegy Ellipta was not administered on 2/9/26 by Nurse #3, with a chart code that referenced the progress notes.</p> <p>Review of the electronic medical record revealed no documentation of a medication administration note written by Nurse #3 on 2/9/26.</p> <p>During an interview on 3/10/26 at 2:29 PM, Nurse #1 stated she had notified the on-call provider on 2/8/26 that the facility was still awaiting delivery of Resident #59's medication from pharmacy. Nurse #1 stated she was given the directive to continue to monitor Resident #59. Nurse #1 confirmed she did not administer Divalproex Sodium, Olanzapine and Trelegy to Resident #59 on 2/6/26 and 2/8/26 because they were not available/on order.</p>	F0760		

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F0760 SS = D	<p>Continued from page 10</p> <p>During an interview on 3/10/26 at 4:26 PM, Nurse #2 stated Resident #59's medications had not arrived on 2/7/26 and she notified the pharmacy on 2/7/26 when Resident #59's medication had not arrived. Nurse #2 confirmed she did not administer Trelegy and Olanzapine to Resident #59 on 2/7/26 because it was on order.</p> <p>Nurse #3 did not respond to a request for interview.</p> <p>An interview was conducted with Resident #59 on 3/10/26 at 10:12 AM. Resident #59 stated he did not have his inhaler and a couple of other medications when he first got to the facility in February. Resident #59 stated the facility did get all his medications, but it took a few days. Resident #59 denied having any adverse effects from not receiving medications.</p> <p>Documentation in the Nurse Practitioner Progress Note dated 2/9/26 at 8:00 AM revealed Resident #59 was seen for a follow up visit for missing medication. The progress note indicated Resident #59 was admitted on Friday and his medications were not delivered until Saturday night. The note indicated Resident #59 had missed doses of Trelegy, Valproic Acid and Olanzapine. Resident #59 was described as calm and cooperative with care. There were no behaviors reported. Resident #59 had oxygen in place and exhibited no shortness of breath. The plan was to monitor Resident #59 for adverse reactions.</p> <p>An interview was conducted with the Nurse Practitioner on 3/12/26 at 12:10 PM. The Nurse Practitioner explained that interruption of Depakote and Olanzapine could cause mood instability and increased behaviors. She further stated that the omission of Trelegy could cause increased breathing issues. The NP stated Resident #59's medication should have been administered as ordered.</p> <p>A health status note dated 2/9/26 at 8:33 AM and written by the Director of Nursing (DON) revealed the on-call provider was made aware that Resident #59 had missed medications. The provider instructed to monitor Resident #59. The note further revealed the DON contacted the pharmacy to find out about Resident #59's missing medications. The note indicated a medication profile had to be created for Resident #59 and the missing medications would be sent out with the next pharmacy delivery.</p> <p>An interview was conducted with the Director of Nursing on 3/11/26 at 2:23 PM. The DON stated that Resident #59 was expected to receive medications as prescribed. The DON stated the medication orders were entered into the</p>	F0760		

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F0760 SS = D	Continued from page 11 system on 2/5/26 and she thought the pharmacy had received the orders electronically on 2/5/26 when they were entered. The DON reported that when the facility became aware that the orders did not transmit electronically to the pharmacy, Resident #59's orders were faxed over to the pharmacy on 2/9/26.  An interview was conducted with the Pharmacist on 3/12/26 at 11:44 AM. The Pharmacist stated that orders were to be faxed to the pharmacy so that a resident profile could be created. The Pharmacist stated delivery of the medications would prevent residents from missing any doses at the scheduled administration times. The Pharmacist confirmed Resident #59's medication orders were faxed to the pharmacy on 2/9/26 and the facility received the medications the night of 2/9/26.  During an interview on 3/12/26 at 11:32 AM, the Administrator stated the facility should have made sure that the resident received his medications on time as prescribed. The Administrator further stated communication with the pharmacy may have prevented the medication errors.	F0760		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary  CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements.  The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.  (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.  (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.  (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F0812	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice  Residents residing in the facility have the potential to be affected by the deficient practice.  Address how the facility will identify other residents having the potential to be affected by the same deficient practice  Residents residing in the facility have the potential to be affected by the deficient practice. On 4/2/26 the Maintenance Director and Dietary Manager audited the kitchen equipment including the HVAC filters to ensure they were free of debris and corrosion.  Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur  On 4/2/26 the Administrator educated the dietary staff including the manager on the need to keep dietary equipment free of debris and corrosion. Education included reporting any issue with equipment or witnessing of corrosion to the Administrator and Maintenance Director. Once the corrosion or uncleanliness has been identified the equipment should not be used until the issue has been resolved. Kitchen	04/04/2026

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F0812 SS = E	<p>Continued from page 12</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations and staff interviews, the facility failed to keep food service equipment free of debris and corrosion by failing to clean 2 of 3 HVAC (heating and air conditioning system) filters observed. This practice had the potential to affect food served to the residents who resided in the facility.</p> <p>The findings included:</p> <p>During the tour of the kitchen with the Certified Food Manager on 3/10/26 at 11:56 AM the kitchen preparation table was observed. Two feet above the food preparation table where wrapped silverware was stacked ready for lunch service, 2 of the 3 HVAC vents were observed with dark debris on the metal vents. The air filter system was off at the time.</p> <p>A second observation on 03/11/2026 11:08 AM the kitchen filters were observed in the same condition with dark debris on the metal vents. The air filter system was on and blowing towards the tray line, 6 feet away. The tray line was not in use at the time.</p> <p>In an interview on 3/11/26 at 11:10 AM the Certified Food Manger stated the HVAC filters were not on a kitchen cleaning schedule as Maintenance came in every 1-2 months to clean the vents. The CFM indicated she was not sure when the filters had last been cleaned.</p> <p>In an interview on 3/11/26 at 11:29 AM the Maintenance Director stated they recently switched company ownership, and the reminder to clean the kitchen vents, was no longer in his Tel's report (software program that tracks and assigns work orders). He indicated the filters looked original that had corrosion and was not sure when he last cleaned the kitchen vents.</p> <p>In an interview on 3/11/216 at 11:30 AM the Administrator stated they would get the HVAC filters replaced and cleaned on a regular basis.</p>	F0812	<p>Continued from page 12</p> <p>staff that did not receive the education by 4/3/26 will not be able to work until the education is received. Newly hired dietary staff will receive the education in orientation from the Administrator.</p> <p>Indicate how the facility plans to monitor its performance to make sure solutions are sustained</p> <p>The Administrator or designee will audit the kitchen equipment including the HVAC filters five times a week for four weeks, then three times a week for four weeks, then twice a week for four weeks to ensure the dietary equipment is free of debris and corrosion.</p> <p>The Administrator is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.</p> <p>Indicate date when corrective action will be completed</p> <p>Completion date: 4/4/26</p>	